FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032011

Facility Name: Norridge Healthcare & Rehab Centre

Address: 7001 W. Cullom Ave. (Number) Norridge (City) 60656 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

IDPA ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-01 to 31-Dec-01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 28-March-2002 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	315	TOTALS	315	114,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,005	18,362	9,450	56,817	8
9	SNF/PED					9
10	ICF	31,167	7,127		38,294	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,172	25,489	9,450	95,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.72%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Jan-1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 8,021

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	405,912	55,973	24,963	486,848		486,848		486,848			1
2	Food Purchase		524,232		524,232	(24,769)	499,463	(1,400)	498,063			2
3	Housekeeping	371,140	128,202		499,342		499,342		499,342			3
4	Laundry	159,484	48,435		207,919		207,919		207,919			4
5	Heat and Other Utilities			268,489	268,489		268,489		268,489			5
6	Maintenance	81,446	55,527	52,816	189,789		189,789	9,717	199,506			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,017,982	812,369	346,268	2,176,619	(24,769)	2,151,850	8,317	2,160,167			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	3,781,084	282,151	64,957	4,128,192		4,128,192		4,128,192			10
10a	Therapy		9,709	86,956	96,665		96,665		96,665			10a
11	Activities	134,287	35,697	2,614	172,598		172,598		172,598			11
12	Social Services	134,678	248	4,639	139,565		139,565		139,565			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Dental Service			480	480		480		480			15
16	**TOTAL Health Care and Programs**	4,050,049	327,805	189,646	4,567,500		4,567,500		4,567,500			16
	C. General Administration											
17	Administrative	91,664		328,500	420,164		420,164	(62,377)	357,787			17
18	Directors Fees											18
19	Professional Services			27,018	27,018		27,018	19,940	46,958			19
20	Dues, Fees, Subscriptions & Promotions			65,320	65,320		65,320	(22,141)	43,179			20
21	Clerical & General Office Expenses	353,288	63,790	130,330	547,408		547,408	42,791	590,199			21
22	Employee Benefits & Payroll Taxes			838,919	838,919	24,769	863,688	59,400	923,088			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,234	4,234		4,234	361	4,595			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			113,471	113,471		113,471	501	113,972			26
27	Other (specify):*							29,168	29,168			27
28	**TOTAL General Administration**	444,952	63,790	1,507,792	2,016,534	24,769	2,041,303	67,643	2,108,946			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,512,983	1,203,964	2,043,706	8,760,653		8,760,653	75,960	8,836,613			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Healthcare & Rehab Centre #0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			95,303	95,303		95,303	523,445	618,748			30
31	Amortization of Pre-Op. & Org.							10,803	10,803			31
32	Interest			72,849	72,849		72,849	392,976	465,825			32
33	Real Estate Taxes			445,232	445,232		445,232		445,232			33
34	Rent-Facility & Grounds			2,484,000	2,484,000		2,484,000	(2,484,000)				34
35	Rent-Equipment & Vehicles			8,486	8,486		8,486		8,486			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,105,870	3,105,870		3,105,870	(1,556,776)	1,549,094			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,509	102,628	251,137		251,137		251,137			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,463	172,463		172,463		172,463			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		148,509	275,091	423,600		423,600		423,600			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,512,983	1,352,473	5,424,667	12,290,123		12,290,123	(1,480,816)	10,809,307			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,607	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,400)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,774)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,102)	21		24
25	Fund Raising, Advertising and Promotional	(25,067)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,826)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,365)	20		28
29	Other-Attach Schedule Deferred Maintenance Costs	2,223	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (110,704)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,370,112)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,370,112)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,480,816)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Norridge Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-01

Ending: 31-Dec-01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,400)	0	0	0	0	0	0	0	0	0	0	(1,400)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	4,494	3,000	0	0	0	0	0	0	0	0	7,494	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,400)	4,494	3,000	0	0	0	0	0	0	0	0	6,094	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(74,592)	12,215	0	0	0	0	0	0	0	0	(62,377)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,940	0	0	0	0	0	0	0	0	0	19,940	19
20	Fees, Subscriptions & Promotions	(35,206)	11,020	2,045	0	0	0	0	0	0	0	0	(22,141)	20
21	Clerical & General Office Expenses	(77,928)	120,705	14	0	0	0	0	0	0	0	0	42,791	21
22	Employee Benefits & Payroll Taxes	0	42,268	17,132	0	0	0	0	0	0	0	0	59,400	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	361	0	0	0	0	0	0	0	0	0	361	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	501	0	0	0	0	0	0	0	0	0	501	26
27	Other (specify):*	0	29,168	0	0	0	0	0	0	0	0	0	29,168	27
28	**TOTAL General Administration**	(113,134)	149,371	31,406	0	0	0	0	0	0	0	0	67,643	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,534)	153,865	34,406	0	0	0	0	0	0	0	0	73,737	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,607	1,453	520,385	0	0	0	0	0	0	0	0	523,445	30
31	Amortization of Pre-Op. & Org.	0	0	10,803	0	0	0	0	0	0	0	0	10,803	31
32	Interest	0	(43,497)	436,473	0	0	0	0	0	0	0	0	392,976	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,607	(42,044)	(1,516,339)	0	0	0	0	0	0	0	0	(1,556,776)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,927)	111,821	(1,481,933)	0	0	0	0	0	0	0	0	(1,483,039)	45

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Salary-Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 226,154	$ 226,154	1
2	V	27	Payroll Taxes		Lancaster, Ltd.	100.00%	29,168	29,168	2
3	V	17	Management Fee Income	328,500	Lancaster, Ltd.	100.00%		(328,500)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	19,940	19,940	4
5	V	21	Office Expenses		Lancaster, Ltd.	100.00%	120,705	120,705	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	42,268	42,268	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	361	361	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	27,754	27,754	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	11,020	11,020	9
10	V	32	Interest	64,761	Lancaster, Ltd.	100.00%	21,264	(43,497)	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	1,453	1,453	11
12	V	6	Maintenance		Lancaster, Ltd.	100.00%	4,494	4,494	12
13	V	26	Professional Liability Ins.		Lancaster, Ltd.	100.00%	501	501	13
14	Total			$ 393,261			$ 505,082	$ * 111,821	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 2,484,000	Norridge Associates	100.00%	$	$ (2,484,000)	15
16	V	30	Depreciation		Norridge Associates	100.00%	520,385	520,385	16
17	V	17	Administrative Consultant		Norridge Associates	100.00%	12,215	12,215	17
18	V	20	Advertising		Norridge Associates	100.00%	1,300	1,300	18
19	V	32	Interest	6,717	Norridge Associates	100.00%	443,190	436,473	19
20	V	31	Amortization Expense		Norridge Associates	100.00%	10,803	10,803	20
21	V	20	Contributions		Norridge Associates	100.00%	745	745	21
22	V	22	Holiday		Norridge Associates	100.00%	17,132	17,132	22
23	V	21	General Expenses		Norridge Associates	100.00%	14	14	23
24	V	6	Resident Room Maintenance		Norridge Associates	100.00%	3,000	3,000	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,490,717			$ 1,008,784	$ * (1,481,933)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	50.0%	see attached	25	38.46%	Lancaster	$ 46,154	17-7	1
2	Laurence Zung	Officer	Administrative	50.0%	see attached	24	50.0%	Lancaster	180,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 226,154		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, Il. 60630
Phone Number: (773)478-3699
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 120,000	$ 120,000	25	$ 46,154	1
2	27	Cynthia Chow	Hours Worked	65	7	6,835	0	25	2,629	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	24	180,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,315	0	24	5,158	4
5										5
6										6
7	19	Professional Services	Management Fees	1,697,900	7	103,061	0	328,500	19,940	7
8	21	Office Expenses	Management Fees	1,697,900	7	27,792	0	328,500	5,377	8
9	22	Employee Benefits	Management Fees	1,697,900	7	218,469	0	328,500	42,268	9
10	24	Education and Seminars	Management Fees	1,697,900	7	1,868	0	328,500	361	10
11	17	Administrative Consultant	Management Fees	1,697,900	7	143,451	0	328,500	27,754	11
12	20	Marketing	Management Fees	1,697,900	7	54,625	0	328,500	10,569	12
13	32	Interest	Management Fees	1,697,900	7	109,907	0	328,500	21,264	13
14	30	Depreciation	Management Fees	1,697,900	7	7,511	0	328,500	1,453	14
15	26	Professional Liability Ins.	Management Fees	1,697,900	7	2,588	0	328,500	501	15
16	20	Licenses and Fees	Management Fees	1,697,900	7	2,330	0	328,500	451	16
17	6	Maintenance	Management Fees	1,697,900	7	23,228	0	328,500	4,494	17
18	21	Salary-Clerical	Management Fees	1,697,900	7	596,087	596,087	328,500	115,328	18
19	27	P/R Taxes-Clerical	Management Fees	1,697,900	7	110,511	0	328,500	21,381	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,898,578	$ 1,076,087		$ 505,082	25

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lincoln National Bank		X	Mortgage	$69,917.94	3/10/93	$ 4,875,000	$ 407,830	6/10/02	9.50%	$ 76,246	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working Capital							21,243	6
7	Harston Investments		X	Working Capital							366,944	7
8	A-1 Credit		X	Financing of Insurance Premiums							1,392	8
9	TOTAL Facility Related				$69,917.94		$ 4,875,000	$ 407,830			$ 465,825	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,875,000	$ 407,830			$ 465,825	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	455,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	447,232	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,768)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	453,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	445,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	401,731	8
1997	406,247	9
1998	441,463	10
1999	446,465	11
2000	447,232	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Healthcare & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773)604-4416 FAX #: (773)478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-18-318-005-0000	Long-Term Healthcare	$ 111,645.68	$ 111,645.68
2.	13-18-318-006-0000	Long-Term Healthcare	$ 111,645.68	$ 111,645.68
3.	13-18-318-007-0000	Long-Term Healthcare	$ 112,294.71	$ 112,294.71
4.	13-18-318-008-0000	Long-Term Healthcare	$ 111,645.68	$ 111,645.68
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 447,231.75	$ 447,231.75

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 165,278
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 10,803
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1986	$ 650,000	1
2	Sect 754 basis adj.			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	315		1986	1976	$ 9,204,000	$ 478,608	30	$ 478,608	$	$ 5,298,436	4
5					1,315,965	41,777	30	41,777		408,371	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20	1,382		24,850	9
10	Various			1988	3,940	125	20	125		2,686	10
11	Various			1988	28,574	1,306	20	1,306		23,270	11
12	Various			1989	1,296	41	20	41		767	12
13	Various			1990	3,827	121	20	121		2,175	13
14	Various			1990	28,644	909	20	909		13,710	14
15	Various			1991	72,916	2,314	20	2,314		32,722	15
16	Various			1992	36,639	1,419	20	1,419		16,136	16
17	Various			1993	72,513	1,920	20	1,920		26,737	17
18	Various			1994	116,349	3,068	20	3,068		39,355	18
19	Various			1995	95,409	2,447	20	2,447		30,772	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	241		2,596	20
21	Tuckpointing			1999	28,900	741	20	741		3,631	21
22	Architect Fee 1st Floor			2001	15,052	338	20	338		338	22
23	Construction 1st Floor			2001	166,662	3,739	20	3,739		3,739	23
24	Construction Library			2001	12,461	280	20	280		280	24
25	Design Fee-1st Floor			2001	5,130	116	20	116		116	25
26	Sprinklers-1st Floor			2001	4,531	102	20	102		102	26
27	Demolition-1st Floor			2001	5,533	124	20	124		124	27
28	Wooden Doors (2)			2001	1,134	25	20	25		25	28
29	Construction Work			2001	4,207	32	20	32		32	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,276,647	$ 541,175		$ 541,175	$	$ 5,930,970	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 331,605	$ 43,049	$ 44,656	$ 1,607	10	$ 204,214	71
72	Current Year Purchases	173,940	29,905	29,905		10	29,905	72
73	Fully Depreciated Assets	974,447	3,012	3,012			974,447	73
74								74
75	TOTALS	$ 1,479,992	$ 75,966	$ 77,573	$ 1,607		$ 1,208,566	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,533,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 617,141	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 618,748	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,607	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,139,536	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 8,486 Description: Minolta Copier @ $707/month
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 40,717	$		$ 40,717	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,565			7,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			54,346			54,346	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				129,852		129,852	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Sup/Sp Bed Rent	39-2					18,657		18,657	13
14	TOTAL			$		$ 102,628	$ 148,509		$ 251,137	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,170	$ 14,260	1
2	Cash-Patient Deposits	73,112	73,112	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,110,672	3,110,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,669	64,669	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	59,557	126,792	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,316,180	$ 3,389,505	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	756,681	756,681	15
16	Equipment, at Historical Cost	1,036,863	1,479,998	16
17	Accumulated Depreciation (book methods)	(979,040)	(9,151,165)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(162,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	100,000	100,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 914,504	$ 4,482,267	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,230,684	$ 7,871,772	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 171,402	$ 171,402	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,078	27,078	28
29	Short-Term Notes Payable	617,740	872,271	29
30	Accrued Salaries Payable	479,138	479,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,971	14,971	31
32	Accrued Real Estate Taxes(Sch.IX-B)	453,000	453,000	32
33	Accrued Interest Payable	51,502	53,747	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,814,831	$ 2,071,607	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,814,831	$ 17,071,607	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,415,853	$ (9,199,835)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,230,684	$ 7,871,772	48

***(See instructions.)**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,205,967	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,205,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,209,886	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,209,886	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,415,853	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,013,695	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,013,695	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,691,820	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(16,905,350)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (14,213,530)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (9,199,835)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,909,874	1
2	Discounts and Allowances for all Levels	(1,309,537)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,600,337	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	484,314	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 484,314	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	38,256	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	195,159	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,428	19
20	Radiology and X-Ray	14,430	20
21	Other Medical Services	136,990	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 409,263	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Vending Commissions**	6,095	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,095	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,500,009	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,176,619	31
32	Health Care	4,567,500	32
33	General Administration	2,016,534	33
	B. Capital Expense		
34	Ownership	3,105,870	34
	C. Ancillary Expense		
35	Special Cost Centers	251,137	35
36	Provider Participation Fee	172,463	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,290,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,209,886	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,209,886	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. *CashBasis Taxpayer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,246	$ 79,692	$ 35.48	1
2	Assistant Director of Nursing	2,485	2,766	78,645	28.43	2
3	Registered Nurses	38,170	40,411	1,049,081	25.96	3
4	Licensed Practical Nurses	36,917	39,317	822,523	20.92	4
5	Nurse Aides & Orderlies	158,432	171,134	1,570,356	9.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,141	39,476	18.44	9
10	Activity Assistants	10,656	11,569	94,811	8.20	10
11	Social Service Workers	8,925	10,125	134,678	13.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,968	44,527	405,912	9.12	15
16	Dishwashers					16
17	Maintenance Workers	5,767	6,253	81,446	13.03	17
18	Housekeepers	36,719	39,424	371,140	9.41	18
19	Laundry	20,645	22,650	159,484	7.04	19
20	Administrator	1,885	2,214	72,404	32.70	20
21	Assistant Administrator	981	1,006	19,260	19.15	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,983	25,076	353,288	14.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	12,992	14,686	180,787	12.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	402,471	435,545	$ 5,512,983 *	$ 12.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	832	$ 24,963	1-3	35
36	Medical Director	750	30,000	9-3	36
37	Medical Records Consultant	120	4,304	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	504	7,560	10-3	39
40	Physical Therapy Consultant	2,484	86,956	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	2,614	11-3	44
45	Social Service Consultant	123	4,639	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,868	$ 161,036		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,771	$ 53,093	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,771	$ 53,093		53

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bernett	Administrator	N/A	$ 72,404
Julie Olds-effective 4/01/01	Asst. Administrator	N/A	19,260
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,664

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd.	$ 328,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 328,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Richard Peelo & Associates	Accounting	$ 2,250
Frost, Ruttenberg & Rothblatt	Accounting	1,175
Winston & Strawn	Legal	4,675
Panarese & Panarese	Legal	50
Personnel Planners, In.	Payroll Tax Consultant	2,180
Purchasing Plus	Purchasing Consultant	600
Health Data Systems, Inc.	Data Processing	9,678
Power Software	Data Processing	2,800
Health Management	Data Processing	58
Medi.Com	Data Processing	1,132
RCN	Data Processing	120
CS Services Inc.	Data Processing	2,300
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,018

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,359
Unemployment Compensation Insurance	41,159
FICA Taxes	416,945
Employee Health Insurance	299,214
Employee Meals	24,769
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	398
Retirement Plan Contributions	18,558
Misc. Employee Benefits	5,286
Lancaster Allocation	42,268
Norridge Associates	17,132
TOTAL (agree to Schedule V, line 22, col.8)	$ 923,088

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	13,268
Health Care Worker Background Check	
(Indicate # of checks performed 85)	1,014
Promotional Advertising	31,432
Contributions	3,774
Dues & Subscriptions	2,373
Licneses & Fees	12,959
Related Parties Allocation	13,065
Less Contributions	(3,774)
Less: Public Relations Expense	( )
Non-allowable advertising	(25,067)
Yellow page advertising	(6,365)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,179

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	866
Seminar Expense	3,368
Lancaster Allocation	361
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,595

**See instructions.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	May-96	$ 10,664	3	$ 3,555	$ 1,777	$	$	$	$	$	$	$
2	Painting & Decorating	Sep-96	13,428	3	4,476	2,238							
3	Painting & Decorating	Nov-96	5,922	3	1,974	987							
4	Painting & Decorating	Jul-97	3,238	3	1,079	1,079	540						
5	Painting & Decorating	Nov-97	2,814	3	938	938	469						
6	Painting & Decorating	Mar-98	4,660	3	777	1,553	1,553	777					
7	Painting & Decorating	May-98	3,318	3	553	1,106	1,106	553					
8	Painting & Decorating	Aug-99	2,834	3		472	945	945	472				
9	Painting & Decorating	Nov-99	1,966	3		328	655	655	328				
10	Painting & Decorating	Mar-2000	585	3		97	195	195	98				
11	Painting & Decorating	Oct-2000	266	3		45	88	88	45				
12	Painting & Decorating	Nov-2000	50	3		8	17	17	8				
13	Painting & Decorating	Dec-2000	180	3		30	60	60	30				
14	Painting & Decorating	Aug-2001	1,281	3				214	427	427	213		
15													
16													
17													
18													
19													
20	TOTALS		$ 51,206		$ 13,352	$ 10,658	$ 5,628	$ 3,504	$ 1,408	$ 427	$ 213	$	$

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,050** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **172,463**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,769** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.